

		FOR OFF USE					

LL1

2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046334

Facility Name: MOSAIC LIVING CENTER

Address: 7464 NORTH SHERIDAN ROAD CHICAGO 60626  
Number City Zip Code

County: COOK

Telephone Number: ( 847 ) 699-7500 Fax # ( 847 ) 699-8148

IDPA ID Number: 01-0759894001

Date of Initial License for Current Owners: 04/01/03

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: BOB KAGDA Telephone Number: ( 847 ) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	BENJAMIN KLEIN	
	(Title)	MANAGER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	( 847 ) 675-3585	Fax # ( 847 ) 675-5777
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number MOSAIC LIVING CENTER

# 0046334 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	150	Skilled Pediatric (SNF/PED)	150	54,750	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,038	1,038	8
9	SNF/PED	30,483			30,483	9
10	ICF		10		10	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,483	10	1,038	31,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 57.59%

D. How many bed-hold days during this year were paid by the Department?  
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 04/01/03

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 04/01/03 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **MOSAIC LIVING CENTER** # **0046334** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	178,776	15,032	10,700	204,508		204,508		204,508			1
2	Food Purchase		246,110		246,110		246,110		246,110			2
3	Housekeeping	84,223	14,671		98,894		98,894		98,894			3
4	Laundry	51,516	10,911		62,427		62,427		62,427			4
5	Heat and Other Utilities			129,240	129,240		129,240	2,885	132,125			5
6	Maintenance	44,948	39,829		84,777		84,777	2,910	87,687			6
7	Other (specify):*			11,280	11,280		11,280		11,280			7
8	<b>TOTAL General Services</b>	359,463	326,553	151,220	837,236		837,236	5,795	843,031			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			32,375	32,375		32,375		32,375			9
10	Nursing and Medical Records	2,284,342	212,588	62,256	2,559,186		2,559,186		2,559,186			10
10a	Therapy	198,939	216	109,053	308,208		308,208		308,208			10a
11	Activities	96,193	17,488		113,681		113,681		113,681			11
12	Social Services	216,697		4,404	221,101		221,101		221,101			12
13	CNA Training											13
14	Program Transportation			4,328	4,328		4,328		4,328			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,796,171	230,292	212,416	3,238,879		3,238,879		3,238,879			16
	<b>C. General Administration</b>											
17	Administrative	71,064		411,096	482,160		482,160	26,319	508,479			17
18	Directors Fees											18
19	Professional Services			92,247	92,247		92,247	2,279	94,526			19
20	Dues, Fees, Subscriptions & Promotions			51,840	51,840		51,840	(9,650)	42,190			20
21	Clerical & General Office Expenses	146,864	36,528	169,914	353,306		353,306	(115,372)	237,934			21
22	Employee Benefits & Payroll Taxes			568,987	568,987		568,987		568,987			22
23	Inservice Training & Education			1,054	1,054		1,054		1,054			23
24	Travel and Seminar							176	176			24
25	Other Admin. Staff Transportation			6,765	6,765		6,765	(1,452)	5,313			25
26	Insurance-Prop.Liab.Malpractice			17,831	17,831		17,831	506	18,337			26
27	Other (specify):*			95,891	95,891		95,891	(83,536)	12,355			27
28	<b>TOTAL General Administration</b>	217,928	36,528	1,415,625	1,670,081		1,670,081	(180,730)	1,489,351			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,373,562	593,373	1,779,261	5,746,196		5,746,196	(174,935)	5,571,261			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	10,700
	REPAIRS & MAINTENANCE		0
			0
			10,700
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		61,980
	ELECTRICITY		58,757
	WATER		8,503
	CABLE TV - LOBBY		0
			0
			129,240
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		0
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		0
			0
			0
			0
			0
7	<b>OTHER</b>		
	SCAVENGER		11,280
	SECURITY SERVICE		0
			11,280
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	32,375
			32,375

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	42,820
	LABORATORY & XRAY EXPENSE		67
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,576
	PHARMACY CONSULTANT	XVIII B 39-2	1,393
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	13,400
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			62,256
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		93,454
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	15,000
	<b>SPEECH THERAPY CONSULTANT</b>	<b>XVIII B 43-2</b>	<b>599</b>
			109,053
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	4,404
			0
			4,404
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	4,328	4,328
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 411,096	411,096
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 8,654	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 83,593	
		0	92,247
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 7,473	
	EMPLOYEE WANT ADS	XIX F 28,225	
	CONTRIBUTIONS	VI 20 XIX F 900	
	DUES & SUBSCRIPTIONS	XIX F 9,354	
	LICENSES & PERMITS	XIX F 3,040	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 1,982	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 866	51,840
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,176	
	EQUIPMENT REPAIR & MAINTENANCE	6,630	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	121,000	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	34,108	
	MESSENGER SERVICE	0	
		0	169,914

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 257,757	
	UNEMPLOYMENT COMPENSATION	XIX D 70,083	
	WORKERS COMPENSATION INSURANCE	XIX D 109,077	
	HOSPITALIZATION INSURANCE	XIX D 123,228	
	EMPLOYEE BENEFITS - OTHER	XIX D 8,842	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	568,987
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,054	1,054
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	6,765	6,765
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	17,831	17,831
27	OTHER		
	BAD DEBTS	VI 24 95,891	
			95,891

GRAND TOTAL COLUMN 3 OTHER

1,779,261

MOSAIC LIVING CENTER  
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
12/31/2005

TOTAL FOOD PURCHASE	246,110	PATIENT MEALS	94593
LESS SALES TAX	0	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	246,110	TOTAL MEALS/YEAR	94593
TOTAL PATIENT CENSUS	31,531	NET FOOD	246110
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	94593
	-----		
TOTAL PATIENT MEALS	94593	COST PER MEAL	2.6
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,043	13,043		13,043	3,875	16,918			30
31	Amortization of Pre-Op. & Org.			21,378	21,378		21,378	348	21,726			31
32	Interest			95,713	95,713		95,713	9,184	104,897			32
33	Real Estate Taxes			20,225	20,225		20,225	3,868	24,093			33
34	Rent-Facility & Grounds			600,495	600,495		600,495	6,841	607,336			34
35	Rent-Equipment & Vehicles			155,825	155,825		155,825		155,825			35
36	Other (specify):*											36
37	TOTAL Ownership			906,679	906,679		906,679	24,116	930,795			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			374,988	374,988		374,988		374,988			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			374,988	374,988		374,988		374,988			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,373,562	593,373	3,060,928	7,027,863		7,027,863	(150,819)	6,877,044			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,027)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,882)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,891)	27		24
25	Fund Raising, Advertising and Promotional	(7,473)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(40,962)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,235)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the  
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,416		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,416		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (150,819)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3  
and 4? If so, they should be reclassified into Section E. Please  
reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47



NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	NON ALLOWABLE TRAVEL	(2,852)	25	2
3	MARKETING SALARY	(38,110)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(40,962)		49

## Summary A

**12/31/2005**

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	HOME OFFICE EXPENSE	\$ 121,000	PLATINUM HEALTH CARE LLC		\$	\$ (121,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 121,000			\$	\$ * (121,000)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	PLATINUM HEALTH CARE LLC	100.00%	\$ 2,885	\$ 2,885	15
16	V	6	REPAIRS & MAINTENANCE				2,910	2,910	16
17	V	17	ADMINISTRATIVE SALARY				26,319	26,319	17
18	V	19	PROFESSIONAL FEES				2,279	2,279	18
19	V	20	FEES & SUBSCRIPTIONS				705	705	19
20	V	21	OFFICE EXPENSES				43,716	43,716	20
21	V	24	EDUCATION & SEMINARS				176	176	21
22	V	25	TRAVEL				1,400	1,400	22
23	V	27	EMPLOYEE BENEFITS				12,355	12,355	23
24	V	26	INSURANCE				506	506	24
25	V	30	DEPRECIATION				743	743	25
26	V	34	OFFICE RENT				6,841	6,841	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 100,835	\$ * 100,835	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OFFICE EXPENSE	\$	PHLG LLC	100.00%	\$ 22	\$ 22	15
16	V	31	AMORTIZATION				348	348	16
17	V	30	DEPRECIATION				11,159	11,159	17
18	V	32	INTEREST				9,184	9,184	18
19	V	33	REAL ESTATE TAXES				3,868	3,868	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 24,581	\$ * 24,581	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		ADMINISTRATIVE					MGMT FEE	\$ 137,032	17-3	1
2	BRIAN LEVINSON		ADMINISTRATIVE					MGMT FEE	137,032	17-3	2
3	MARK SHAPIRO		ADMINISTRATIVE					MGMT FEE	137,032	17-3	3
4	BEN KLEIN		ADMINISTRATIVE					SALARY	26,319	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 437,415		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number      MOSAIC LIVING CENTER      #    0046334    Report Period Beginning:      01/01/2005      Ending:    2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      PLATINUM HEALTH CARE LLC  
Street Address      7444 LONG AVENUE  
City / State / Zip Code      SKOKIE, IL 60077  
Phone Number      ( 847)329-4100  
Fax Number      ( 847)329-4900

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	415,423	11	\$ 38,007	\$	31,531	\$ 2,885	1
2	6	REPAIRS & MAINTENANCE	TOTAL PATIENT DAYS	415,423	11	38,341		31,531	2,910	2
3	17	ADMINISTRATIVE SALARY	TOTAL PATIENT DAYS	415,423	11	346,750	346,750	31,531	26,319	3
4	19	PROFESSIONAL FEES	TOTAL PATIENT DAYS	415,423	11	30,027		31,531	2,279	4
5	20	FEES & SUBSCRIPTIONS	TOTAL PATIENT DAYS	415,423	11	9,282		31,531	705	5
6	21	OFFICE EXPENSES	TOTAL PATIENT DAYS	415,423	11	575,967	429,868	31,531	43,716	6
7	24	EDUCATION & SEMINARS	TOTAL PATIENT DAYS	415,423	11	2,319		31,531	176	7
8	25	TRAVEL	TOTAL PATIENT DAYS	415,423	11	18,439		31,531	1,400	8
9	27	EMPLOYEE BENEFITS	TOTAL PATIENT DAYS	415,423	11	162,778		31,531	12,355	9
10	26	INSURANCE	TOTAL PATIENT DAYS	415,423	11	6,673		31,531	506	10
11	30	DEPRECIATION	TOTAL PATIENT DAYS	415,423	11	9,790		31,531	743	11
12	34	OFFICE RENT	TOTAL PATIENT DAYS	415,423	11	90,129		31,531	6,841	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,328,502	\$ 776,618		\$ 100,835	25



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1							\$		\$			\$	1		
2													2		
3													3		
4													4		
5	RELATED PARTY											9,184	5		
	Working Capital														
6	DR TOM KLEIN		X	WORKING CAPITAL	INTEREST							18,000	6		
7	MB FINANCIAL		X	LINE OF CREDIT	INTEREST	4/1/2003	1,500,000	1,500,000	4/5/2004	4.5000		76,185	7		
8	RELATED PARTY											1,528	8		
9	TOTAL Facility Related						\$	1,500,000	\$	1,500,000			\$	104,897	9
	B. Non-Facility Related*														
10	IRS, IDR, ETC		X	LATE FEES										10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	1,500,000	\$	1,500,000			\$	104,897	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>		\$	108,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	110,639			2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,639			3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	108,000			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$				5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(90,414)			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	20,225			7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2000		8		
		2001		9		
		2002	73,978	10		
		2003	179,731	11		
		2004	110,639	12		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

MOSAIC LIVING CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0046334

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE ( 847 ) 675-3585

FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	11-29-307-019-0000	NURSING HOME	\$ 25,303.63	\$ 25,303.63
2.	11-29-307-020-0000	NURSING HOME	\$ 24,487.92	\$ 24,487.92
3.	11-29-307-022-0000	NURSING HOME	\$ 60,847.80	\$ 60,847.80
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 110,639.35	\$ 110,639.35

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    X    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

## X. BUILDING AND GENERAL INFORMATION:

**A. Square Feet:** 51,316 **B. General Construction Type:** Exterior BRICK Frame **Number of Stories**

**C. Does the Operating Entity?** ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)**

**D. Does the Operating Entity?** ☒ (X) (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (X) (c) Rent equipment from Completely Unrelated Organization.

**(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)**

**E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**

**F. Does this cost report reflect any organization or pre-operating costs which are being amortized?** ☒ YES ☐ NO  
If so, please complete the following:

<b>1. Total Amount Incurred:</b>	<b>106,890</b>	<b>2. Number of Years Over Which it is Being Amortized:</b>	<b>5</b>
----------------------------------	----------------	---	----------

<b>3. Current Period Amortization:</b>	<b>21,378</b>	<b>4. Dates Incurred:</b>	<b>04/01/03</b>
--	---------------	---------------------------	-----------------

**Nature of Costs:** \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

### A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number MOSAIC LIVING CENTER

# 0046334

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		SEWER DRAIN WORK		2003	7,400	269	27.5	269		660	9
10		COMPRESSOR		2003	2,565	93	27.5	93		230	10
11		BOILER & AC		2003	876	32	27.5	32		79	11
12		CARPETING, SHADES & WALLPAPER		2003	10,463	1,004	5	1,004		8,956	12
13		DUMBWAITER REPAIR		2003	4,347	158	27.5	158		388	13
14		INSTALLED VERTICAL BLINDS		2004	4,489	163	27.5	163		238	14
15		INSTALLED SPRINKLER HEADS		2004	5,033	183	27.5	183		267	15
16		ELECTRICAL WORK		2004	4,607	168	27.5	168		245	16
17		REMODEL RESIDENTS ROOMS, BATHROOM & SHOWER ROOM		2004	18,950	690	27.5	690		1,010	17
18		ALARM SYSTEM		2004	7,115	259	27.5	259		379	18
19		REMODEL OFFICES, LOBBY AND BATHROOMS		2004	31,125	1,132	27.5	1,132		1,659	19
20		ROOF AND LAUNDRY ROOM RENOVATION		2004	7,900	286	27.5	286		404	20
21		REPL FIRE PUMP		2005	9,995	166	27.5	166		166	21
22		REPIPE KITCHEN SINK		2005	5,550	91	27.5	91		91	22
23		DOOR ALARM		2005	2,247	37	27.5	37		37	23
24		CARPETING		2005	1,265	22	5	253	231	253	24
25		INFARED SAFETY EDGE		2005	1,850	32	27.5	32		32	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$125,777	\$4,785		\$5,016	\$231	\$15,094	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 51,313	\$ 6,731	\$	\$ (6,731)		\$	71
72	Current Year Purchases	7,635	1,527		(1,527)			72
73	Fully Depreciated Assets							73
74	RELATED PARTY							74
75	TOTALS	\$ 58,948	\$ 8,258	\$	\$ (8,258)		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 184,725	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 5,016	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,027)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 15,094	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CDS,LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 600,495			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 600,495			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 149,375 Description: SEE SCHEDULE ATTACHED  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2003 FORD WINDSTAR	\$ 338.21	\$ 3,022	17
18		2005 4 RUNNER WINDS	400.00	3,428	18
19					19
20					20
21	TOTAL		\$ 738.21	\$ 6,450	21

10. Effective dates of current rental agreement:

Beginning 4/1/03

Ending 4/1/18

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	4/1/2006	\$ 603,453
13.	4/1/2207	\$ 615,522
14.	4/1/2008	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,830,928		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,508		6
7	Other Prepaid Expenses	7,272		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>R.E.TAX ESCROW</u>	105,361		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,976,069	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	125,777		15
16	Equipment, at Historical Cost	58,949		16
17	Accumulated Depreciation (book methods)	(58,345)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	106,890		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(58,790)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 174,481	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,150,550	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,440,220	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,325,000		29
30	Accrued Salaries Payable	104,482		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 3,011,861	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,011,861	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (861,311)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,150,550	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (685,075)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (685,075)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(176,236)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (176,236)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (861,311)	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,851,627	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,851,627	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,851,627	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	837,236	31
32	Health Care	3,238,879	32
33	General Administration	1,670,081	33
	<b>B. Capital Expense</b>		
34	Ownership	906,679	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	374,988	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,027,863	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(176,236)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (176,236)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.  
TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,040	2,248	\$ 87,811	\$ 39.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,619	30,464	736,136	24.16	3
4	Licensed Practical Nurses	9,429	13,451	223,135	16.59	4
5	CNAs & Orderlies	71,349	75,429	709,557	9.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,684	9,420	198,939	21.12	8
9	Activity Director	1,526	1,594	25,869	16.23	9
10	Activity Assistants	5,817	6,557	70,324	10.73	10
11	Social Service Workers	10,245	10,758	216,697	20.14	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	45,870	22.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,051	15,333	132,906	8.67	15
16	Dishwashers					16
17	Maintenance Workers	3,174	3,324	44,948	13.52	17
18	Housekeepers	9,341	10,359	84,223	8.13	18
19	Laundry	5,552	6,450	51,516	7.99	19
20	Administrator	2,000	2,080	71,064	34.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,994	9,437	146,864	15.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,025	1,075	16,097	14.97	31
32	Other Health C: RESPIRATORY	19,226	28,539	511,606	17.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	198,024	228,598	\$ 3,373,562 *	\$ 14.76	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 10,700	1-3	35
36	Medical Director		32,375	9-3	36
37	Medical Records Consultant		4,576	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		1,393	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		15,000	10a-3	42
43	Speech Therapy Consultant		599	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		4,404	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 69,047		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	68	\$ 3,900	10-3	50
51	Licensed Practical Nurses	931	38,920	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	999	\$ 42,820		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.







## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? \_\_\_\_\_
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL ON LONG CARE \$6388
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 374,988  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees